

**UNITED STATES HOUSE OF REPRESENTATIVES  
COMMITTEE ON ENERGY AND COMMERCE  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**

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**TESTIMONY OF DR. ALAN M. MILLER, Ph.D, M.D.  
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**August 1, 2007**

Mr. Chairman and members of the Committee: Thank you for the opportunity to again testify about the state of health care in the New Orleans region and specifically the future of our physician workforce.

I also want to thank members of the Committee for their continuing support for the region's rebuilding efforts. Since the March hearings and through your efforts a number of actions have been taken that will have an immediate impact on healthcare for the most vulnerable of our citizens. It is now time to turn our attention to the long-term stabilization of health care. Central to that goal is the the impact of Graduate Medical Education (GME) on the region's supply of future doctors. GME is a key component in the growth and stability of healthcare in Louisiana. Prior to Katrina, according to the Association of American Medical Colleges, the number of medical students and residents for 100,000 persons trained through Louisiana's GME programs was well above the national average. Louisiana retained close to 50% of its trainees, ranking second among states in the percentage of physicians practicing in the same state as they were trained. The training of a qualified and committed physician workforce will assure the future of care in New Orleans and Louisiana, but unless the region's medical schools and teaching hospitals receive support, the survival of these programs will be in jeopardy.

I represent Tulane University, an institution of higher education whose mission includes both the provision of healthcare and the training of our next generation of doctors.

Critical to any discussion of healthcare in New Orleans must be how to ensure that our training programs remain vibrant so that Tulane and LSU can continue to attract the best and brightest. Therefore today, I'd like to focus my comments on four key areas.

1. The role of Graduate Medical Education in providing the region's health care;
2. Short and long term needs associated with maintaining and growing an adequate physician workforce to meet patient needs.
  - a. Ability to negotiate directly with hospitals to place residents in appropriate training programs;
  - b. Exemption of the 3 year rolling average for host hospitals
3. The role of the VA in physician training
4. Financial stability for the region's healthcare providers

### **Role of Tulane and Graduate Medical Education**

To date, Tulane University's cumulative financial losses from Hurricane Katrina are nearing \$600 million. As of August, 2007 we have recovered approximately \$300 million from insurance, FEMA, Federal recovery and foundation grants. As I said in my previous visit to the Committee, the past two years have been extremely challenging for everyone in New Orleans, but especially for those of us attempting to assess healthcare needs, rebuild broken systems, continue to provide care for all New Orleanians who need it, and effectively train our young physicians. Despite these challenges, Tulane University as the largest employer in Orleans Parish has continued to do exactly what it has done since its creation in 1834: provide health care, educate physicians, and advance medical knowledge through research and discovery in New Orleans and Louisiana.

The tragedy of Katrina has energized our nation's young adults like no event in our history. Thousands of high school and college students continue to flock to New Orleans to assist their fellow Americans in rebuilding their lives. Likewise we have seen an increased interest from future health care professionals who feel compelled to be a part of the rebuilding process. As one of the nation's leading research intensive medical schools, Tulane has always drawn some of the most talented students from around the country and resident training in New Orleans has always been of the highest quality. Now, students and residents are also offered an unparalleled opportunity to learn first hand about community based care and disaster recovery. But to be effective we must have quality training sites or some of our programs could be forced be closed. Before Katrina, Tulane University had 620 medical students, with a first year class of 155, and 521 residents and fellows trained in 44 programs. Post-Katrina, we received 7,000 applications for admission and increased the class size last year to 165. It will increase this year to 175. After losing the Medical Center of Louisiana at New Orleans (MCLNO), we voluntarily downsized our resident training programs to maintain their quality. We now have 331 residents training in 36 programs. LSU has faced a similar downsizing of its residency programs. It's important to note that each year that Tulane and LSU train a reduced number of residents the state faces long-term problems in terms of the supply of physicians in Louisiana.

### **Short and long term needs associated with maintaining and growing an adequate physician workforce to meet patient needs**

The experience of the New Orleans healthcare institutions revealed flaws in the current system for reimbursing GME that are still impacting Tulane, LSU and our host hospitals,

and will undoubtedly be repeated in other cities if a disaster results in the total or partial closure of a major teaching hospital for an extended period of time. That is unacceptable. Prior to Katrina, both Tulane and LSU trained medical residents at several area hospitals, but the one site where both schools had their largest concentration of residents was the MCLNO. As a result of Katrina the hospitals comprising MCLNO were closed for 15 months. Although they have since partially reopened, they are only able to accommodate a portion of the total residents trained before the storm.

The financing of GME is, even under ordinary circumstances, a complicated and complex maze of agreements and reimbursement procedures that can often be navigated only with the assistance of attorneys. Simply put, before Katrina, CMS provided payments to MCLNO for the costs of training and in turn MCLNO reimbursed the medical schools so that they could provide for the salaries and benefits of residents and fellows. While there are other models around the country, because our residents train in multiple hospitals, they are paid directly by the medical schools in order to maintain consistency in payment and benefits. It's important to keep in mind that during the period of total and partial closure, the medical schools remained responsible for the education of the residents, and for paying the salaries and benefits despite being unable to receive reimbursement from the closed hospitals. As a result, Tulane lost \$6 million in FY 05-06 and anticipates a loss of \$1.5 million for FY 06-07.

The issue of finding temporary hospital placements for residents during the Katrina disaster was, in part, a function of Medicare's cap on the number of reimbursable training

slots that a hospital may have. Tulane was able to identify hospitals that were willing to accept displaced residents. Given the moratorium on any increase in training slots at existing programs, however, these hospitals were reluctant to agree to reimburse Tulane for displaced resident salary and benefits because the receiving hospitals were, in many cases, at or above their Medicare resident cap.

The regulatory solution to the Medicare cap dilemma has become a bureaucratic nightmare, so much so that Tulane had to engage outside counsel to navigate the unwieldy process. Unlike the relatively simple pre-Katrina experience, in order to place residents in alternative training locations Tulane and LSU must now identify hospitals capable and willing to take in additional residents. These host hospitals must provide appropriate supervision, adequate libraries, call rooms and laboratories to meet accreditation criteria. Tulane and LSU are the responsible accrediting parties, not the host hospitals. After identifying the sites, MCLNO as the “owner” of the Medicare-reimbursable resident slots must then, at the prompting of the medical schools, enter into emergency Medicare GME affiliation agreements with each of the hospitals for the specified number of slots. These agreements allow MCLNO to transfer some of its unused slots to the host hospitals, thus allowing the host hospitals to seek reimbursement from CMS for the displaced residents. As previously noted, without these agreements, most host hospitals would be unable to seek reimbursement from CMS because most hospitals are already training residents at or over their resident “caps.” At the same time the medical schools must enter into separate Affiliation and Reimbursement Agreements with the host hospitals to provide the training and reimburse the medical schools for the

salaries and benefits of the residents. Once this laborious process is completed, the agreements must be renegotiated and renewed annually until the residents return to their home hospital, in this case MCLNO. It is worth repeating that in Louisiana, Tulane and LSU, NOT the host hospitals, are responsible to the accrediting agencies of residency programs, to assure the quality of the training programs at each hospital and payment of salaries and benefits to the residents.

Undoubtedly the most critical flaw that remains is that Medicare does not in all cases reimburse the institution that bears the direct responsibility for training the residents and paying their salaries and benefits. This then exacerbates the financial stress placed on responsible institutions during the disaster and recovery period. However we are not here today to ask for direct reimbursement. Instead we asking only for help in reducing our administrative burden by giving administrative stewardship of the slots allocated to closed or partially closed hospitals such as MCLNO to the medical schools so that we may directly negotiate with the host hospitals to place our residents.

We propose the following:

When it is clear that a teaching hospital that functions in partnership with a medical school(s) for GME will be totally or partially closed for an extended period of time (greater than 30 days), the “slots” that cannot be supported educationally and financially by the hospital should be placed in the “stewardship” of the medical school(s) by CMS such that the medical schools assume the financial responsibility for supporting the displaced residents.

- If multiple medical schools are involved, the slots would be divided according to the usual proportion of distribution under full operations.
- The medical school(s) would enter into an agreement with the originating hospital specifying the number of slots and period of time for which they would have stewardship. This would be tailored to coincide with the originating hospitals plans for wholly or partially reopening.
- The medical school(s) would then be able to enter into agreements with receiving hospitals to provide training for a specified number of residents, and reimbursement of the school(s) for their costs.
- The medical school would continue to pay residents and faculty and steward the well-being of the program, while the receiving hospital would receive GME payments.

Stewardship would continue as long as the originating or home hospital could not support its total approved slots, and would be adjusted annually based on the originating hospitals ability to educationally and financially support the slots. The overall process would be far simpler than the current one, while assuring the integrity of the GME programs and its financial support during the recovery period.

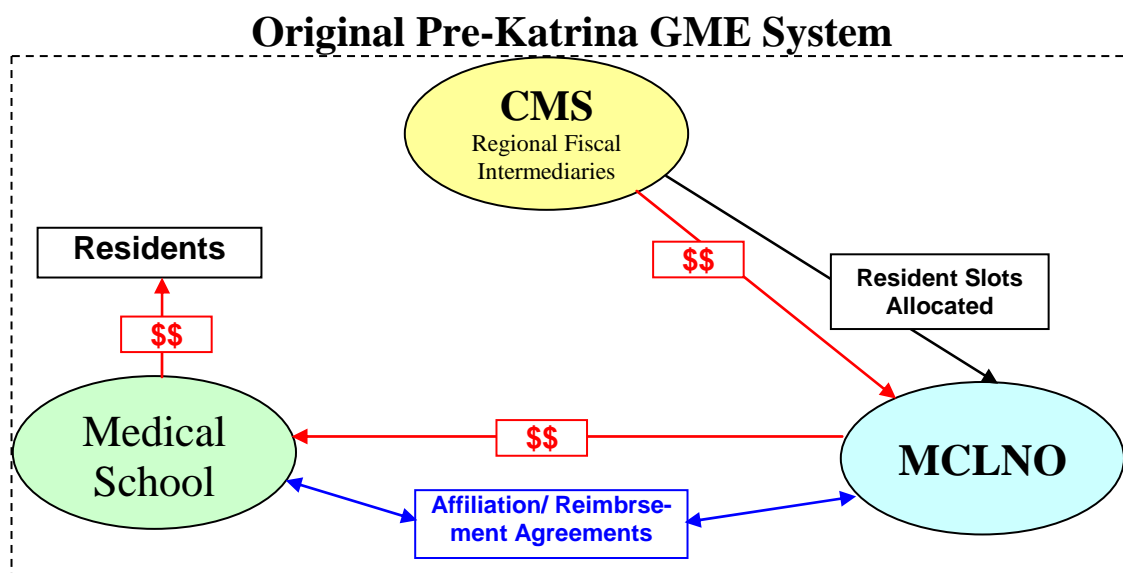


Figure 1

## Current Post-Katrina GME System

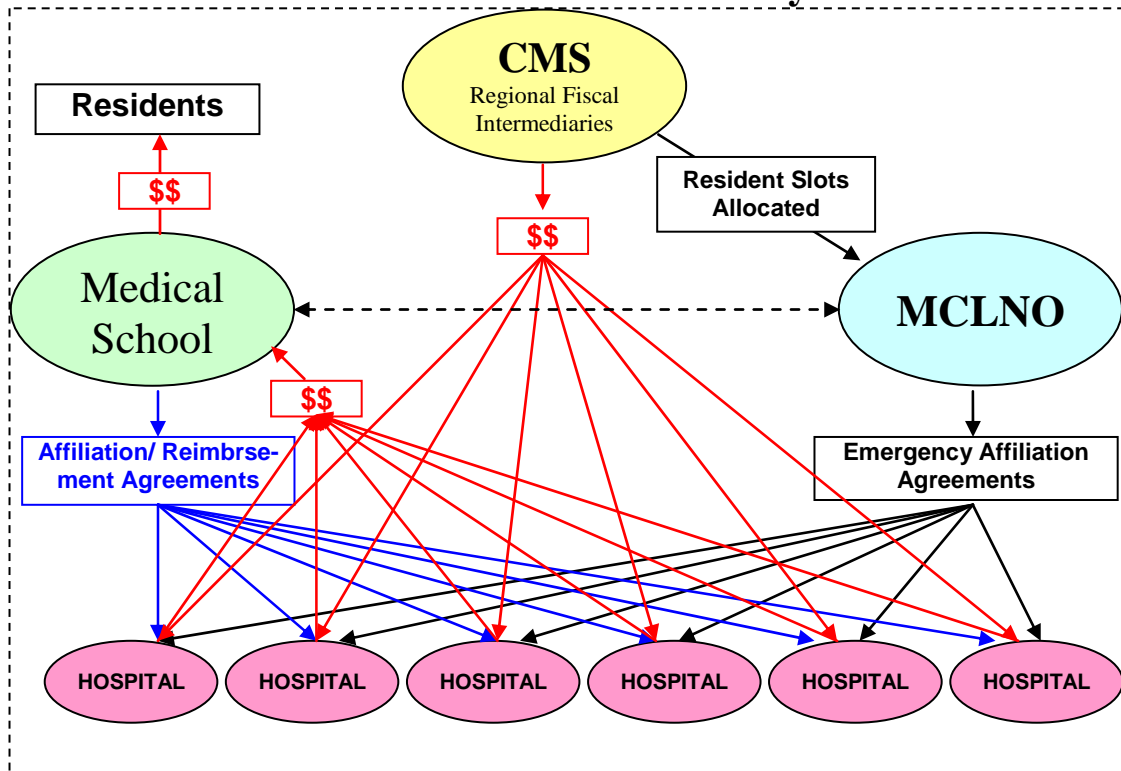


Figure 2

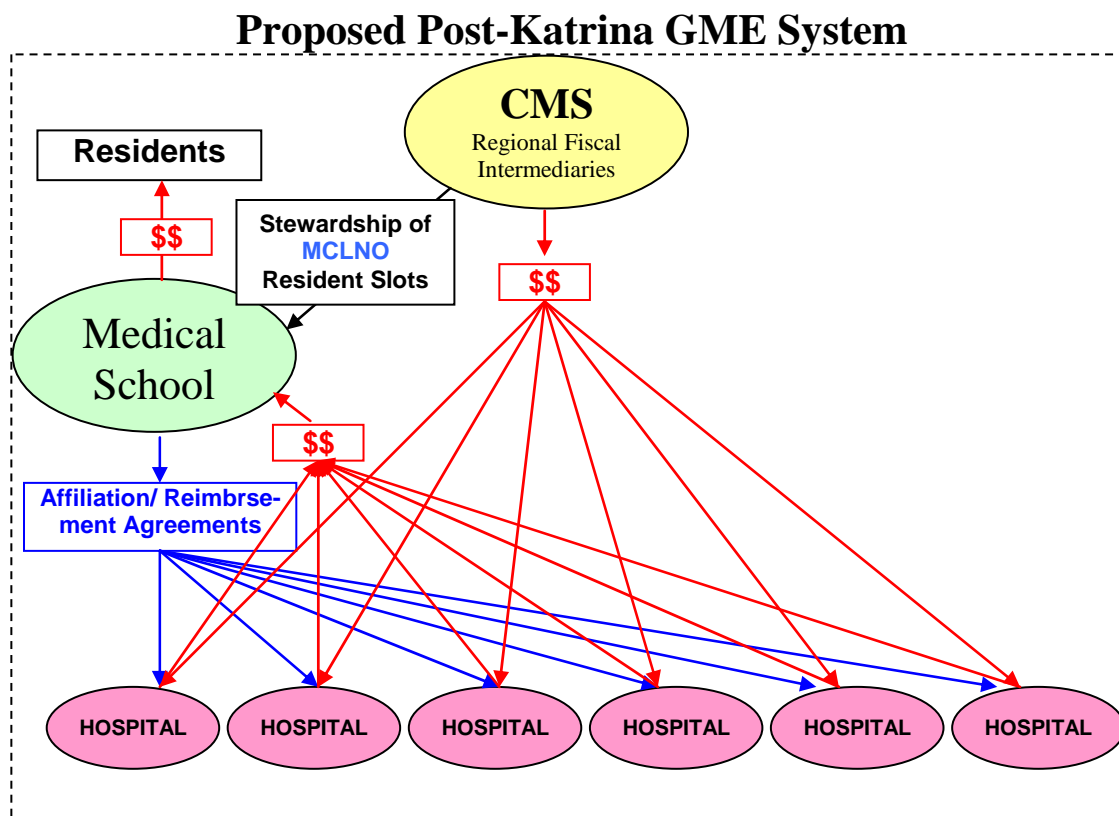


Figure 3

### **Exemption from 3 Year Rolling Average**

Following Katrina, CMS waived the application of the 3 year rolling average for affected hospitals from August 29, 2005 to June 30, 2006, to allow host hospitals to include all of the displaced residents in their FTE count, and hence full GME payments for those slots, immediately. This was important to the financial well being of the hospitals but also to medical schools which needed to continue to collect money from those host hospitals for resident and faculty salaries.

Unfortunately as time has passed there remains a need for shifts in training locations. In the first year post-Katrina many of our residents were placed at training sites outside of

the region and state. As the region recovered and the Medical Schools returned to their downtown locations, residents were relocated to other host hospitals in the New Orleans region. Tulane and LSU are finding it necessary to continually adjust the location of residents and programs as original training hospitals gradually re-open beds, and as feedback from accreditation surveys require adjustments.

In July, 2006, the 3 year rolling average was reinstated. Since that time, host hospitals that have accepted additional residents are reporting significant financial impact due to the rule and in many cases they have been unable to fully reimburse the medical schools, creating an additional burden for Tulane and LSU. This is especially troublesome in the current financial environment of substantial increases in un-reimbursed care. This could result in some hospitals being unable to accept residents.

We request that Congress instruct CMS to provide an exemption of the 3 year rolling average for host hospitals taking in displaced residents. The exemption is requested for 5 years with a re-evaluation on an annual basis until a replacement MCLNO is completed.

### **The Role of the VA in Resident Training**

Prior to Katrina, Tulane University provided approximately 70 percent of the patient care at the VA, with more than 75 Tulane faculty physicians serving joint appointments with the VA in many medical, surgical, and psychiatric sub-specialties and advanced clinical services. The VA Medical Center and Hospital in New Orleans provided training for approximately 140 residents, 120 of whom were from Tulane.

The VA's integration with the health sciences centers at Tulane and LSU provided a critical synergy that was a key strength both for the New Orleans VA and the region's overall health care standing. The quality of the healthcare provided to our veterans was enhanced by the association with the medical schools, and their highly skilled clinical faculty. The VA continues to play a crucial role in graduate medical education and medical research in New Orleans.

Today, the VA's outpatient clinics have reopened and visits are up to 75% of the pre-storm numbers. In addition, through its partnership with Tulane, the VA is now providing much-needed inpatient care at Tulane University Hospital and Clinic as it strives to keep up with the rapidly expanding population. Currently, the VA is supporting an average of 26 Tulane residents per month who are involved in outpatient care. If more VA beds were available, Tulane would increase the number of residents there to 70.

In addition to our residents, more than 40 Tulane physicians are currently providing services and training at various VA locations in the area, representing more than \$2.2 million in physician compensation. In addition, numerous other Tulane faculty physicians are frequently available for service at VA locations as needed. The Tulane Health Sciences Center is now actively recruiting new physicians to accommodate the increasing need in the area and has open searches for five faculty positions specifically to support the clinical mission at the VA.

As we look down the road five, 10, 20 years and longer, it's clear that the VA will continue to be a cornerstone in the future of health care and the biosciences industry in the region. These industries already represent a significant share of New Orleans' regional economy. More than 8,000 people are employed in the bioscience and health related fields, with the metro area ranking 67<sup>th</sup> in the country. Prior to Katrina, the New Orleans Bioscience District was actively building a framework for entrepreneurial success. As a crucial component of that framework, the LSUHSC, Tulane University and the State of Louisiana formed both the Louisiana Gene Therapy Research Consortium and the Louisiana Cancer Research Consortium (LCRC). These partnerships are focused on leveraging the universities' research and education strengths to position the region as a leading center for clinical, biomedical and translational research, and to increase the area's competitiveness for large-scale research projects funded by the National Institutes of Health. In support of the region's efforts to expand its bioscience and biomedical infrastructure, the State of Louisiana also provided support for the creation of a 60,000-square-foot New Orleans BioInnovation Center (NOBIC). This center is designed to support the area's growing bioscience community, to attract additional biotechnology investment, and to foster the commercialization of new technologies and pharmaceuticals developed in the vibrant New Orleans Bioscience District. With additional funding provided this year by the state legislature, construction will begin this fall in the downtown bioscience district on an \$86 million cancer research facility, and the \$60 million BioInnovation Center.

The synergy generated by Tulane, LSU, the construction of the BioInnovation Center and the LCRC building, each within a few city blocks of the other, will create a rich, dynamic teaching and research environment that will rival any in the country. A strong VA Medical Center is a crucial component of this burgeoning bioscience hub that will maximize the potential of both the district and of the VA. It is hard to imagine the district without the VA, and the VA being built anywhere but the district.

Although it may have taken longer than many of us would have hoped, the state has done its part in providing funding for a public hospital to be built in tandem with the VA. This leverages the federal government investment, providing substantial cost savings and demonstrating good stewardship of taxpayer dollars. In addition, the investments by the state, city, and our own institutions in the emerging bioscience district provide a unique opportunity to create a vibrant inter-reliant collaboration among key healthcare, education and research entities, all of which are crucial to the VA's mission. It is the hope of Tulane University, as well as that of the many local and regional stakeholders (see attached letter) in the biosciences, that the VA and the City of New Orleans move quickly to begin the process of land acquisition, planning and construction so that we may re-establish the full spectrum of care for our rapidly growing veteran population.

### **Financial stability for the region's healthcare providers**

According to the Louisiana Department of Health and Hospitals there were 617 primary-care physicians in New Orleans prior to Katrina. By April 2006 that number had dropped to 140, a decrease of 77%. In July 2006, Blue Cross Blue Shield of Louisiana reported a 51% reduction in the total number of physicians filing claims in Region I. Nearly all of

this reduction—96%—was from Orleans Parish. The loss of additional clinical faculty at Tulane as well as LSU will not only decrease the available current physician workforce, but will reduce the clinical teaching faculty needed to teach the next generation of physicians for the region and the state. Our region's hospitals are here today to request funds to keep them financially viable, I would ask that you not forget the doctors in the area who are providing care and remain uncompensated for that care. Providing funds for uncompensated care provided at the hospitals will not directly assist our physicians, therefore we request a separate Federal allocation specifically for physicians so that we can stem the tide of physicians leaving the area.

Once again, I thank you for your continued attention and support in overcoming the challenges that we face.